Ontario. Legislative Assembly.
Select committee on Health-care
financing and costs Report

Ontario

LEGISLATIVE ASSEMBLY

1978

REPORT OF THE

SELECT COMMITTEE ON HEALTH-CARE

FINANCING AND COSTS

BRUCE McCAFFREY, M.P.P.
CHAIRMAN

OCTOBER 17, 1978

THE LETTER OF SUBMISSION

TO: The Honourable John E. Stokes
Speaker of the Legislative Assembly of the
Province of Ontario

Sir:

We the undersigned, Members of the Select Committee on Health-Care Financing and Costs, appointed by the Legislative Assembly of the Province of Ontario on June 19, 1978, have the honour to submit the attached Report.

Bruce McCaffrey, M.P.P.
Chairman

Robert Mackenzie, M.P.P.

Sean Conway, M.P.P.

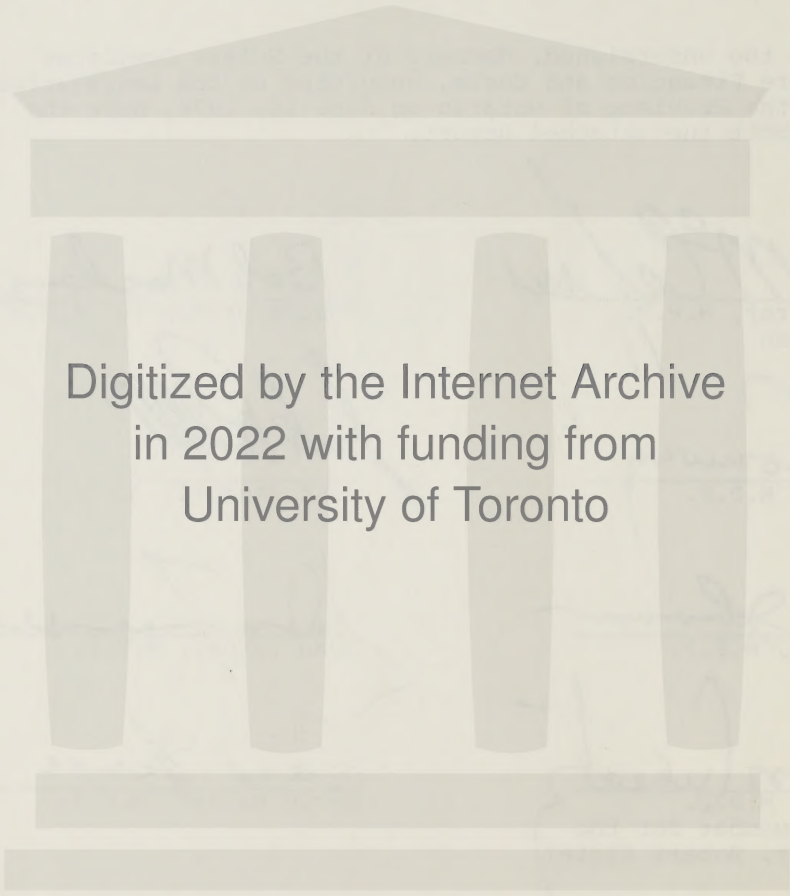
Jack Riddell, M.P.P.

Jack Johnson, M.P.P.

John Turner, M.P.P.

Sam Cureatz, M.P.P.
(substitute Member for the
Honourable Dr. Robert Elgie)

David Warner, M.P.P.



MEMBERS OF
THE SELECT COMMITTEE ON HEALTH-CARE
FINANCING AND COSTS

Bruce McCaffrey, M.P.P. (Chairman)	Armourdale
Robert Mackenzie, M.P.P.	Hamilton East
David Warner, M.P.P.	Scarborough-Ellesmere
Sean Conway, M.P.P.	Renfrew North
Jack Riddell, M.P.P.	Huron-Middlesex
Jack Johnson, M.P.P.	Wellington-Dufferin-Peel
John Turner, M.P.P.	Peterborough
Sam Cureatz, M.P.P.	Durham East
Dr. Robert Elgie, M.P.P.	York East

S T A F F

Counsel	Donald H. Rogers	Thomson, Rogers Barristers & Solicitors
Consultants	Dr. Alan Wolfson Dr. Greg Stoddart	University of Toronto McMaster University
Clerk of the Committee	Douglas Arnott	
General Administrator to the Committee	Franco Carrozza	
Seconded from Ministry of Health	Mirvyn Hanna Yale Drazin	
Research Assistant	Susan French	

Acknowledgment

The Committee would like to acknowledge the excellent cooperation and assistance it received throughout from the staffs of the Ministry of Health and the Ministry of Treasury and Economics.

* During the course of the Committee's work Dr. Robert Elgie was appointed Minister of Labour and was replaced as Chairman of the Committee by Mr. Bruce McCaffrey. Mr. Sam Cureatz subsequently took Dr. Elgie's place as a Member of the Committee.

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INTRODUCTION

The Committee's terms of reference contained three specific areas of consideration:

1. "To review Ontario's health-care costs, health-care financing methods, and services provided for that expenditure; and then to compare that profile with those of other provinces and countries as the committee may deem appropriate for purposes of providing a valid basis for comparison.

2. To review alternative methods of financing the health-care system and the impact of those alternatives on the fiscal and economic affairs of the Province; and to make recommendations thereon.

3. To review existing reports which relate to methods and means of containing or reducing health-care costs, and to report its findings to the Legislature."

The Committee attempted to deal with each of these through 21 days of public hearings during which time some 94 witnesses gave evidence. In addition, the Committee received 189 written submissions from various institutions and members of the public. The Committee also reviewed an imposing number of existing reports and documents dealing with the same subject matter.

We would like to express our appreciation to those who took the time and trouble to make their views known to the Committee. Those opinions weighed very heavily in the conclusions reached in this report. The report which follows is divided into sections, each dealing with a specific term of reference.

TERM OF REFERENCE NO. 1

The first term of reference calls for review of:

1. Ontario health-care costs;
2. health-care financing methods; and,
3. the services provided for that expenditure,

and comparison of that profile with other provinces and countries as deemed appropriate by the Committee for purposes of providing a valid basis of comparison.

In order to establish the historical and comparative background, the three areas are best dealt with in reverse order.

SERVICES PROVIDED BY THE ONTARIO HEALTH-CARE SYSTEM

The health-care system of Ontario forms part of the national health insurance programme in Canada. The programme is based on the policy that every citizen has the right to adequate health care and it is the government's responsibility to assure that right. The principles of the programme, widely known as the "four points", are:

1. universal coverage;
2. comprehensive benefits;
3. portability of benefits; and,
4. public administration and accountability.

The key events in developing the programme were: the passage of the federal Hospital Insurance and Diagnostic Services Act and the introduction of the Ontario hospital insurance plan (Ontario Hospital Services Commission) in 1959; and, passage of the federal Medical Care Act and Ontario's entry into Medicare in 1969 with the introduction of the Ontario Health Services Insurance Plan. These plans, which were merged into the Ontario Health Insurance Plan in 1972, established the basic benefit package covering all medically necessary services, both in hospital at standard ward level and provided by physicians outside hospitals, as well as a limited list of dental-surgical services provided by dentists in hospitals.

The basic package, and the two-stage phasing in of initial services, led first by hospital services and then, a decade later, by medical services, were national in scope.

The cost-sharing arrangements with the Federal government had the effect of encouraging an overall emphasis in the decade of the sixties on the expansion of hospital services. This one-sided emphasis created distortions. For example, there was excessive hospital construction in the 1950's. Later, when hospital services were insured and medical services were not, there was an "insurance bias" in favour of treating patients in the hospital setting. The Ministry of Health has undertaken programme initiatives in Ontario aimed at rationalizing the health-care system. Thus, especially after 1972, emphasis has been on controlling costs and rationalizing health services

through the encouragement of alternatives to active treatment in patient care, such as nursing homes, day surgery and more appropriate placement of users of the system at the level of care needed. A pilot Home Care project was started as early as 1961.

The comparison of Ontario with other provinces in terms of services provided by the health-care system thus reveals a basic core programme common to all provinces with minor variations in extended health benefits, such as dental health coverage for school-age children in Nova Scotia.

The countries selected by the Committee for comparison are: Sweden, the United Kingdom, West Germany and the United States. Comparison of benefits across those countries becomes an almost impossible task. For example, Swedish figures include child supplement benefits, and maternity and sickness cash benefits, while the U.K. includes, among others, dental and ophthalmic services. Approximately 90 per cent of the population of West Germany are members of the compulsory health scheme and the rest are privately insured by a variety of different schemes. Benefits include sick pay and death benefits among others. The United States exhibits by far the most diverse picture with a great variety of benefit packages insured through Federal and State programmes, private insurance and employment and group insurance plans.

Ontarians have access to a comprehensive range of medically necessary services at the highest standard of quality and, in this respect, Ontario compares very favourably with any jurisdiction in the world. Though there is a theoretical

universality of access, it must be qualified by noting some problems with the geographical distribution of physicians in Ontario. There are physician shortages, for example, in a number of areas in northern Ontario and even in some southern localities. Programmes, such as the Underserviced Areas Programme, and the establishment of District Health Councils to advise the Ministry of local needs, are aimed at improvement in this area.

Across provinces there is considerable variation in the mix of services utilized. For example, in British Columbia utilization of ambulant care is higher than in the rest of the country while use of the hospital system is considerably less. As well, though the basic benefit package is comprehensive as far as medically necessary services are concerned, there is scope for expansion of health services. For example, half the population of Ontario does not receive regular dental care. Alberta, Saskatchewan, Nova Scotia, Prince Edward Island and Newfoundland do provide a range of dental services not available in Ontario and the Committee recommends that high priority be given to consideration of a school-age dental programme in Ontario as an extended health benefit.

HEALTH-CARE FINANCING METHODS

Unlike the national health insurance programme which has lead to provision of a fairly uniform package of health-care benefits across Canada, each province has a tax and revenue structure which is different and rooted in specific historical circumstances.

Jurisdictional comparisons across provinces, except for those that finance a relatively small part of their health expenditures out of "health related revenues" are almost impossible. The "health related revenues" are:

1. direct user charges;
2. premiums; or,
3. health "labelled" taxes.

The revenue produced by premiums, utilization fees and "labelled" taxes amounts to only a portion of health-care expenditure. In Ontario the proportion was originally struck at one-third and at present is about a quarter. It is not possible to say how health-care is financed without a complete examination of the total tax structure and the distribution of income in each province, and that is beyond the terms of reference of this Committee.

In Ontario, private insurance was a particularly vigorous industry that covered most of the population prior to medicare. Based on the Hagey Committee Report which recommended "continued activity of private insurance carriers issuing standard contracts under regulations adopted by a government appointed body subject to a degree of supervision by that body" the government introduced a bill in 1965. There was public hostility to the high maximum rate for those in a poor risk category and concern about the use of private insurance plans as public carriers and a voluntary government plan known as the Ontario Medical Services Insurance Plan was set up in 1966. Thus when medicare was introduced in 1969 the collection of a premium as a way to fund "insured services" was a continuation of established practice.

To a certain extent, the same was true of other provinces. In 1962, premiums and other "labelled" hospital service taxes, such as a portion of the sales tax or property tax, were used by six provinces: Manitoba, Prince Edward Island, Saskatchewan, Alberta, British Columbia and Ontario. The first three of these provinces subsequently abolished labelled taxes and premiums. Alberta and British Columbia began with utilization fees and have retained them and later have introduced premiums to fund medical services although they have abandoned labelling portions of sales and property taxes as health-care taxes. Saskatchewan introduced utilization fees in 1968 and then abolished them in 1971. Quebec introduced a payroll tax when it entered medicare. Thus at present Ontario, Alberta and British Columbia collect premiums and Quebec has a "labelled" payroll tax. Small utilization fees are also collected in a number of provinces, such as an $8.50 per diem charge for utilization of extended care or home care services in Ontario.

In the United States the medicare programme for the aged is financed by a payroll tax of one per cent payable each by the employee and the employer; the medicaid programme for low income individuals is financed by federal and state revenues. Supplementary optional medical insurance for the elderly is financed by contributions by beneficiaries that are matched by the federal government.

In the United Kingdom health care is 87 per cent financed from general revenues with an additional 10 per cent coming from social security contributions paid by employers and employees and 3 per cent coming from user charges for dental and ophthalmic services and pharmaceuticals.

Sweden gets 25 per cent of its public health-care financing from general revenues, and 75 per cent from a payroll tax on employers and the self-employed. There are additional user charges for hospital, dental and physician services paid directly to the provider.

In West Germany there are over 1,500 separate compulsory sickness insurance funds covering 90 per cent of the population with employer/employee contributions determined by each fund as a percentage of earnings subject to various ceilings.

HEALTH CARE COSTS

Health care is a labour intensive industry. As such total costs are largely incurred in the purchase of the human resources needed to run the system. The cost of human resources is the product of the number of health care workers multiplied by their average remuneration. This product in turn is identical to the product of the volume of services utilized multiplied by the average unit price of those services.

There are two major cost items. Hospital care accounts for 50 per cent of health-care costs. Medical services account for 25 per cent of health-care costs. Professor Robert Evans has analyzed the factors that have affected these costs in Canada for the period 1950 to the present.

MEDICAL COSTS

a) 1950-1965

Increases in medical costs were due mostly to increases in physician incomes. Little is known about the utilization of services, but fees were rising.

b) 1965-1971

This was a period of rapid cost escalation with incomes increasing and an especially rapid increase in the number of physicians. In Ontario the ratio of population per active fee for service physician went from 1079 in 1965 to 931 in 1971.

c) 1971-1975

The rapid increase in the number of physicians continued but the increase in total cost slowed as both incomes and fees levelled out toward the end of the period.

d) 1975 - present

Medical costs continued to be relatively constrained as a result of moderation in the increase in the number of physicians though there was some increase in average incomes.

HOSPITAL COSTS

a) 1950-1960

There was rapid increase in utilization as measured by patient days per 1000 population. This was most likely in response to hospital construction and took place under private insurance.

b) 1961-1970

Increases in utilization slowed though there was some increase in hospitalization. There were increases in hospital per diem rates. Early in the period wage demands were moderate but they increased more rapidly toward the end of the decade.

c) 1971 - present

Hospital utilization was flat. Numbers of workers levelled off but incomes increased until the Anti-Inflation Board guidelines came into effect.

Having looked at the highlights of what was influencing costs in Canada as a whole over the period 1950 to the present, it is now appropriate to examine cost increases in Ontario.

Good data exist for the post-medicare period 1970/71 to 1978/79. Over this time total health expenditures rose from about 1 1/2 billion dollars to about 4 billion dollars.

As a percent of gross provincial product Ministry of Health expenditures have fluctuated around 4.4 per cent reaching a high point of 4.6 per cent in 1975/76 and falling to an estimated 4.2 per cent in 1978/79. As a proportion of provincial budget, health expenditures have been gradually declining from about 30 per cent in 1972/73 to about 28 per cent in 1978/79.

"Total health expenditures" refers to only those expenditures made by the Ministry of Health. To the extent that other health related activities such as Workmen's Compensation, medical schools, occupational health and safety, etc., originate in other Ministries such as Labour, "total health expenditures" is an understatement of the share of resources currently committed to health programmes. Furthermore, the composition of the provincial "total health expenditure" series does not correspond to that of the federal series "total health expenditures for Canada". The latter attempts to allow for private as well as public spending on health, the former does not. This constitutes a second source of underestimation in the share of resources going to health indicated by the provincial series.

Cost increases for the major components of health expenditures over the 1970/71 to 1978/79 period are shown in the following table:

HEALTH EXPENDITURES BY MAJOR COMPONENT

PROGRAMME	TIME PERIOD TO 1978/79	PERCENTAGE CHANGE	1978 $ (millions)
Public Hospitals	1970/71	177	2136.6
Health Insurance	1970/71	119	958.5
Extended Health Care	1972/73	325	130.6
Psychiatric Services	1970/71	85	210.8
Other (includes Ministry Administration)	(1)	(1)	508.0
TOTAL	1970/71(2)	160	3944.5
Gross Provincial Product	1970/71	167	94.2 (billion)
Total Provincial Budgetary Expenditure	1970/71	171	14005.0

(1) Includes many programmes, for example, public health, home care, ambulance services, etc., some of which were implemented after 1970/71. Consequently, both the base amount and percentage change figures would tend to be misleading. For example, the following three programmes, which account for only 4.3 per cent of 1978/79 total health expenditures, all experienced substantial increases over the period from 1970/71 to 1978/79: Public Health costs increased 166 per cent; and Home Care costs, 780 per cent. From 1974/75 to 1978/79 the Drug Benefit programme costs increased 974 per cent.

(2) Based on a standardized benefit package to ensure comparability across time.

INTERPROVINCIAL COMPARISONS

Comparisons are made on the basis of a standardized benefit package. In terms of provincial government expenditures per person on health, Ontario has, over the period 1966-1977, moved in step with the overall trend in other provinces, giving the lead in cost increases up to about 1971 and having the lowest percentage increases after that period compared to Saskatchewan, Quebec, British Columbia and Canada excluding Ontario.

In 1975/76 only Alberta and Manitoba had higher per capita provincial government expenditures on health; British Columbia and Quebec had slightly lower per capita health expenditures, while Saskatchewan and the Atlantic provinces expended considerably less for health on a per capita basis.

As a percentage of personal income, only British Columbia and Saskatchewan spent less on health.

In terms of the major components, on a per capita basis, Ontario expended more on hospital care than all but Alberta and Manitoba and Quebec, more than all but British Columbia for other personal care, and less than all but Quebec and Newfoundland on public health in fiscal 1975/76.

Comparing across provinces there was considerable variation in the mix of the various components and this may be partly a result of data problems. Thus British Columbia appears to emphasize ambulant care and de-emphasize hospital care which

may be a result of the higher fee schedule and physician/population ratios in British Columbia but may also be partly a result of the way provinces allocate costs between categories covered by hospital and medical insurance. Ontario's profile by components is similar to the rest of Canada taken as a whole.

In 1976 Ontario was second lowest after British Columbia in population per general practitioner at 1,250:1 and third lowest after British Columbia and Quebec in population per specialist at 1,379:1. Ontario had the second highest per capita expenditure for physician services at $85.00. Over the period 1968 to 1976 population/physician ratios for all the various provinces have moved together for both generalists and specialists from levels around 2,000:1 to the levels noted above even though there is wide variation across provinces in the ratio for any given year. Including interns and residents the population per active civilian physician, including general practitioners and specialists, was 538 in 1977.

The hospital picture is fairly complex. In Ontario the number of beds per capita is lower than in the rest of Canada and has been declining since 1965 in line with the rest of Canada and at a faster rate than the rest of Canada since 1971. Only Newfoundland has fewer beds per capita than Ontario. Ontario is also second lowest in active treatment beds taken as a separate category. With one of the highest occupancy rates, Ontario is in the mid-range of provincial experience with respect to admissions per capita, length of stay, and, patient days per capita. Ontario was about average in terms of total paid hours per patient day in public general hospitals in 1975.

Because Ontario was using its hospital resources more intensively than other provinces, operating expenses per patient day for total public hospitals were high in Ontario. In fact, only Newfoundland, the only province with fewer beds per capita, had higher operating expenses per patient day than Ontario in 1975.

INTERNATIONAL COMPARISONS

Data problems in comparing expenditures on health care components across Canada have been mentioned above. These problems are, of course, greatly compounded in international comparisons. For West Germany, the United Kingdom, Sweden and Canada cost figures used are for governmental expenditures but the definition of what should be counted as health care costs of course varies. In looking at the United States figures, private as well as governmental expenditures for "direct expenditures for health" are included. Comparisons at any given point in time are of dubious meaning but trend analysis is less subject to problems of definition and greater confidence can be placed in comparison of trends.

The cross-national comparative figures for 1975 show Canada to be in the mid-range, exceeded by Sweden, West Germany and the United States, and exceeding the United Kingdom in terms of expenditures on health care as a percentage of gross national product. Canada is second only to West Germany in physicians per capita. Though Canada has the lowest ratio of beds per capita it ranks third in bed-days and second in admissions.

In terms of trends in health-care cost increases Canada compares very favourably with the United States. As a percentage of the G.N.P., Canada's health-care expenditures increased approximately 0.2 per cent and the United States' 0.9 per cent between 1974 and 1976.

Looking at Canadian and United States' statistics that attempt to allow for private as well as public spending on health-care, in 1960 Canada was expending 5.6 per cent of Gross National Product on health and this was more than in the United States where the share was 5.3 per cent of G.N.P.

Health continued to take a greater share of G.N.P. in both countries but by 1969 the U.S. had overtaken Canada and both countries were devoting 6.7 per cent of G.N.P. to it. Since then, Canada, under medicare, has contained expenditures for health to around 7 per cent of G.N.P. while in the U.S. there has been a continued increase to 8.9 per cent in 1977.

On balance it would appear that cost control in Ontario is relatively effective. On the basis of the evidence however, there are no grounds for complacency. The elderly are on average the heaviest users of the health system and they are a growing proportion of the Ontario population. The aging phenomenon is but one aspect of the paradox of health care: namely, that medical advances spur increased demand by enabling people to live longer and consume more expensive treatment.

To the extent that cost containment has been realized by rationalizing a health-care system that had built-in distortions over the years, there are limits to how many further opportunities

for rationalization can be found. However, the comparison with the United States in recent years indicates that there are cost savings to be had by developing and maintaining a well-managed rationally integrated health-care delivery system.

TERM OF REFERENCE NO. 2

The Committee spent much of its time and energy considering the very complex matter of health care financing. In particular, the Committee was most concerned about the fiscal and economic impacts of alternative ways of financing health care expenditures. Revenues collected by premiums currently are almost $1 billion and thus constitute a significant item in the entire tax system. The Committee has been sensitive to the magnitude of the task of tax reform, even in a restricted area such as the premium system.

In its deliberations the Committee considered a number of alternatives and in each case evaluated them along several dimensions including equity, efficiency, feasibility, flexibility, visibility and continuity. Moreover it sought out and analyzed data on the potential impact of various proposals on people in various income categories. Although the data on tax incidence are not as comprehensive as could be desired, the Committee feels that it has been able to assess the general implications of each financing alternative.

In particular, in its assessment of the working of the current system, the Committee was distressed to learn that only about one-third of those eligible for full premium assistance have applied for that assistance, and that almost none of those eligible for partial premium assistance is currently taking advantage of this relief.

The Committee does wish to express its concern about the quality of the data made available to it and suggests that more detailed analysis be undertaken in the context of implementing its major recommendations.

Having considered several alternatives, the Committee reached consensus on one major issue and unanimously recommends that the current subsidy system be replaced by a tax credit system that would ensure -- as the current subsidy system does not -- that all those entitled to premium assistance in fact receive it. While details of this proposal remain to be worked out, the format would involve retaining subsidies until the end of fiscal 1978/79, at which time those eligible for tax credits would receive them when filing income tax returns, and would then apply those credits against premiums payable in the forthcoming fiscal year. We estimate that nearly one-half million tax filers would benefit by such a system.

With respect to the means of financing the tax credit, there was majority support within the Committee for the recommendation that, as the tax credit results in a net additional revenue requirement, this be financed by reliance on progressive tax sources, recognizing that the ultimate responsibility for fiscal policy in Ontario must rest with the Treasurer.

On a number of other issues no consensus was reached; the diversity of opinions held is indicated by the separate statements of each party, which follow.

Statement of Members Representing the Progressive Conservative Party; Mr. Jack Johnson, M.P.P., Mr. Sam Cureatz, M.P.P., and Mr. John Turner, M.P.P.

We believe we have responded fully to an exploration of the terms of reference which were developed at the insistence of the Liberal Party of Ontario earlier this year, and which were predicated upon the assertion that, "...the OHIP premiums must be supplanted by more progressive forms of revenue raising..."*

Having reviewed exhaustive expert testimony, and upon full consideration of the evidence presented before the Committee, our position emerges as outlined below:

Recommendation 1

The current premium system, although not without flaws, should merit the continued support of the Government.

Recommendation 2

Any increase in personal income taxes during the current economic period should be regarded as both ill-advised and inconsistent with the public welfare.

Recommendation 3

There is evidence to support the position that the current subsidy mechanisms, though well-intended, are not performing as effectively as they should. Accordingly, they

* Source: Liberal Party Communique, April 18th, 1978

should be replaced by a tax credit system that would ensure -- as the current subsidy system does not -- that all those entitled to premium assistance in fact receive it. While details of this proposal remain to be worked out, the format would involve retaining subsidies until the end of fiscal 1978/79, at which time those eligible for tax credits would receive them when filing income tax returns, and would then apply those credits against premiums payable in the forthcoming fiscal year. We estimate that nearly one-half million tax filers in Ontario would benefit by such a system.

Recommendation 4

The Ministry of Health should receive acknowledgement of its success in constraining health costs, while delivering a consistently high level of services to the people of Ontario.

Recommendation 5

Notwithstanding the substance of recommendation 2, we believe that the ultimate responsibility for fiscal policy in Ontario must rest with the Treasurer in the context of his broader responsibilities to the economic integrity of this province.

These hearings have confirmed OHIP as a sound health delivery system with fundamentally effective financing. Our approach underlines our willingness to make careful and responsible change where the evidence presented has indicated such a need.

Statement of Members Representing the Liberal Party;
Mr. Sean Conway, M.P.P., and Mr. Jack Riddell, M.P.P.

Last April, the Liberal Caucus submitted a position paper regarding the Government's proposal to increase the OHIP premiums by 37.5 per cent. In the course of that paper, the following statement was made:

> The Liberal Caucus remains persuaded that the OHIP premiums must be supplanted by more progressive forms of revenue-raising... The premium system obviously cannot be abolished overnight; the generation of some $850 millions (at current rates) by other forms of taxation will require extensive research and reflection. Only the naive--or the politically irresponsible--will claim that the problem can be solved by a sudden loading of such revenue requirements on the personal income tax, or the corporation income tax, or the sales tax, or some arbitrary mix of all three. Comprehensive tax impact studies will be required in order to determine the most equitable arrangement or alternatives to the OHIP premium.

During the hearings of the Select Committee on Health Care Financing and Costs, no evidence has been submitted to cause our Party to change the opinion we expressed at that time. If anything, the testimony presented to the Select Committee indicates clearly that the premium system is even more regressive and inefficient than we had thought. The premium system is simply a form of taxation and a bad one at that. We remain adamantly opposed to the premium system and a Liberal government would move in its first term of office

to abolish that system and replace it by a more adequate and progressive one.

The premium system should never have existed. Most other provinces do without it. Once a billion dollar system is in place, however, people adjust to it and it becomes a complex matter to replace it with a different billion dollar system. It can (and should) be done but it must be done gradually and with due attention paid to the disruptions such a change may bring about.

The work of the Select Committee during the past four months has been made particularly difficult by the mass of inadequate and conflicting data which have only served to confuse and make more difficult the task at hand. We are frankly surprised and dismayed to see how little the government knows about the impact of the premium system and its alternatives, and about the extent to which assistance programmes have been taken up.

We have been unable to assess the full impact of the alternatives to the premium system through the material that has been provided to us by the Treasury. To obtain adequate data would require certain surveys to be done, which will take several weeks to prepare. In particular, we believe that more attention needs to be paid to the impact a move from the premium system would have on certain groups and on labour/ management relations.

Let us be more specific. The fairest tax to replace the regressive premium tax would appear to be the personal income tax. But, apart from higher income groups, certain other groups might be adversely affected and we need more information about that. Firstly, tax-paying elderly people, presently exempted, would presumably pay something via the income tax route. We need to consider the possible impact of varying the tax credit system for the elderly so as not to treat harshly those provident elderly citizens who live on fixed but adequate incomes after a lifetime of serving the community. Secondly, moderate income families with more than one wage earner might be adversely affected. To know more about this, we need a survey to tell us the nature of these families, the exact impact on these persons and possible means of minimizing such an effect. Thirdly, there are certain people at the lower end of the income scale, the so-called working poor, who would need special assistance.

Fourthly, and in some ways, most importantly, there is the matter of the many working persons whose premiums are paid by the employer. Can we be certain that all these people will receive in wages the total amount now being paid in premiums? Can we be sure that certain employers, especially in non-union establishments, would resist the temptation to reduce their payroll costs or, possibly, to refuse any real wage increases on the basis of the shift from premiums being an <u>apparent</u> increase? A survey of employers is required. Furthermore, it may well be that employees fail to understand the system and, if they are to obtain the benefits they deserve, they may have to be clearly

advised of the reality of the situation. In the absence of such an informational programme the shift might precipitate difficulty at the labour/management interface at a time of economic difficulty and high unemployment.

Given these far-reaching and critical uncertainties, we recommend:

1. that the Select Committee recommend that, from now on, the OHIP premium rate be frozen;

2. that the Select Committee recommend a partial shift immediately to Personal Income Tax in order to provide a more generous assistance programme for low income earners. This will provide additional support, in particular, to the working poor.

3. that the Select Committee recommend that its mandate be extended until March 31, 1979;

4. that the Select Committee commission tax impact studies and surveys so that it may assess objectively alternative methods of funding the health care system, especially via personal income tax;

5. that the Select Committee commission a study of the impact a move from the premium system would have on labour/management relations.

Statement of Members Representing the New Democratic Party; Mr. Bob Mackenzie, M.P.P., and Mr. David Warner, M.P.P.

Last spring the government of Ontario attempted to increase OHIP premiums 37 1/2 per cent, an increase which would have meant a doubling of premiums in a two-year period. As a result of the combined opposition in the Legislature and other public reaction, the Treasurer felt compelled to modify the increase. At the same time the Select Committee on Health Care costs was created. Although the Committee's mandate consisted of three terms of reference, it was clear from the beginning, that the main purpose of the Committee was to examine and recommend alternative methods of financing the health care system.

This has proved to be a difficult and frustrating task. We, as New Democrats, have always argued that, firstly, premiums are a regressive tax and should be abolished. Secondly, health care in Ontario should be financed through progressive tax revenue. On the first point, the great majority of expert witnesses and the majority of Committee Members agreed the present system is inequitable. On the second point, however, there was no such agreement. Indeed, there were not even alternative proposals.

In the course of our long deliberations over the various methods of funding health care and the problems associated with each, it became obvious that it is almost impossible to consider major changes in a tax which will raise $975 million this year without examining the whole Ontario tax system and its need

for reform. And it proved equally frustrating to consider premiums and health cost containment in isolation from an examination of major health system reform.

We were prepared to look seriously at any proposals that replaced the unfair premium structure with a more progressive and equitable method of financing health care costs in Ontario. Nonethe-less, we carefully and forcefully argued that this could best be done with a switch from premiums to personal income tax; in this way, contributions are based on one's ability to pay. We recognize that this means some additional costs for high income earners and for two-income families without children with a combined income of more than $25,000. But most Ontario residents will be better off. Such a plan should be progressively phased in. In this way, should the economic climate improve, the option exists to replace part of the premium revenue with other progressive tax sources such as the corporate income tax.

Merely to state an intention to abolish premiums eventually is not sufficient. The commitment must be reflected by a reduction of the present premiums now, and in each of the next three years, in the order of 25 per cent per year.

In order that workers not lose where OHIP is a negotiated benefit, the shift from premiums must be accomplished by legislation to guarantee that the value of the benefit is retained by workers as either a wage increase or another benefit of choice.

We recognize that there is a special problem regarding premium assistance programmes for low-wage earners. Both the Ministry of Health and the Treasury argued that the premium assistance programme added a measure of progressivity to premiums. However, evidence presented to the Committee, evidence which seemed to shock both the Ministries, indicated that out of a potential take up of $200,000,000 for such assistance, only $50,000,000 was, in fact, being applied for. Only 162,000 of the 487,000 people entitled to full premium assistance are receiving it and fewer than 1,000 of those 160,000 entitled to partial assistance are receiving it.

This information not only undermined any claims of progressivity in the present premium system, but also cast doubt on the reliability of the government's figures and predictions in terms of financing. Thus, the impact of any combinations of premium, personal income tax, and tax credit systems that were presented to the Committee at its request, became suspect.

The resulting perception that $150,000,000 of funding was needed to merely meet the coverage supposedly already available added another major factor to be considered in any alternative method of financing. And the awareness of the deficiency of available government information added to our frustration and concern that the Committee's discussions were not fully informed.

We regret the lack of willingness to do more than talk about the merits of more equitable funding for the future provisions of health care. There is more than sufficient evidence to conclude that the premium system is very regressive. It is time that a decision of principle be taken. We, as New Democrats, believe that a total replacement of premiums with progressive tax revenues is the only equitable solution. This also provides a guarantee that increasing health costs and, hopefully, expanded services, can be met by increased income generated by rising incomes.

We respectfully file this minority statement outlining our position and our frustration at the Committee's failure to deal substantively with its major term of reference.

TERM OF REFERENCE NO. 3

The Committee received a host of suggestions concerning means of curtailing overall health care costs. In addition, the Committee staff analyzed existing studies and reports on this topic and a copy of the staff summary is attached as an exhibit and is available upon request.

Obviously it was not possible for the Committee to deal specifically with each of these proposals in this report, but we do wish to comment particularly upon the following topics.

USER CHARGES AND OPTING-OUT

A good deal of the Committee's time was devoted to the consideration of user charges in various forms. This topic is one which bridges the second and third terms of reference of the Committee. If user charges in fact constitute deterrent fees and inhibit utilization of health services, they can contribute to cost containment; if they do not deter sufficiently to lessen total costs, they represent a source of additional revenue. The issue is further complicated by the many guises under which user charges may appear in the system: in addition to direct charges made to patients at the time of service, user charges can occur in the form of co-insurance or deductible payments in connection with insured services, treatment of health services received as taxable income, supplementary charges by physicians under a balanced-billing scheme, charges by opted-out physicians in excess of the O.H.I.P. benefit, and so forth.

One cannot, then, sensibly address the topic of user charges without consideration also of the question of physician remuneration and we shall treat these two issues together.

In the first instance, the appropriateness of user charges as deterrent fees depends crucially on three assumptions:

1. There exists a significant amount of utilization of health services that is either frivolous, or of "borderline necessity", or for some other similar reason, ought not to occur;

2. This "abuse" of health services is related to the fact that there are no direct charges for these services, and the imposition of such charges would reduce or even eliminate the abuse.

3. Non-abusive utilization, the use of health services which ought to occur, would not be affected by the imposition of user charges.

The Committee has given careful consideration to each of these assumptions, has sought out evidence and testimony relating to each and concludes that all three are not supported by the facts that have been presented. Although anecdotal accounts of patient abuse are available, the Committee is not convinced that this problem is wide-spread. On the contrary, evidence provided by Dr. Carolyn Tuohy, based on a recent survey of nearly 600

ntario physicians, indicates that only about 10 per cent of services provided were not medically necessary in the opinion of the physician. Interestingly, the same survey indicated that a higher percentage of patients, about 12 per cent, waited too long before seeking medical attention. Furthermore, the Committee heard no evidence suggesting that frivolous use of health services is concentrated among patients who would be sensitive to moderate user charges; the classic hypochondriac is unlikely to be deterred by their imposition. Finally, the Committee is concerned about the potential negative effects of deterrent charges in inhibiting legitimate use of the health care system by those who either could not afford even moderate charges, or at least would perceive these charges as representing a barrier to access. In particular, the Committee notes the Saskatchewan experience with deterrent fees in the period 1968-1971, when there was only a marginal reduction in overall utilization, but a significant decrease in the utilization rates of the poor. Interestingly, the utilization rates of richer patients actually rose during the period of "deterrent" fees. Such a distortion in the pattern of care would be entirely unacceptable in the Committee's view.

The problem with deterrent fees, then, is that in general they cannot be expected to deter very much, but in particular they may deter altogether the wrong people.

This brings us to a consideration of the general problem of access to health services. In a context where there are differential charges to different kinds of patients, the question of equal access to the health system comes to the fore. This

could occur under a scheme of "balanced-billings" where physicians bill both OHIP and patients, or in the case of opted-out physicians. Indeed, proponents of direct-billing have suggested to the Committee that special treatment be afforded to the "medically indigent", in order to countervail the undesired deterrent effects. Such a policy, however, goes entirely against the grain of our public health insurance programme, which is committed to ensure equal access to the health care system, without regard to the ability to pay. In this connection, the Committee notes Section 4(1)(b) of the Medical Care Act, R.S.C. 1970, Chapter M-8:

> "the plan provides for and is administered and operated so as to provide for the furnishing of insured services upon uniform terms and conditions to all insurable residents of the province, by the payment of amounts in respect of the cost of insured services in accordance with a tariff of authorized payments established pursuant to the provincial law or in accordance with any other system of payment authorized by the provincial law, on a basis that provides for reasonable compensation for insured services rendered by medical practitioners and that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons."

The Committee is particularly concerned about three aspects of this statement. First, the Committee endorses the principle of providing insured services on "uniform terms and conditions to all insurable residents of the province", and questions whether the uniformity of access is consistent with different charges for different kinds of patients, as could occur under balanced-billings, and as does occur to some extent in the case of opted-out physicians. Second, in light of the

Saskatchewan experience, the Committee is fearful lest the imposition of user charges, in whatever form, impedes or precludes reasonable access to insured services by insured persons. In particular, the Committee is troubled by recent increases in the proportion of physicians who are opting-out of O.H.I.P., particularly when most or all of the physicians in a community opt-out. This constitutes a direct challenge to the principle of universal access. The Committee endorses the government's commitment to ensuring universal access and welcomes the statement by the Minister of Health that the government will not allow opting-out to compromise this principle, and that in particular affected communities the Ministry could encourage the creation of a group practice under an alternative payment programme in order to ensure adequate access.

Finally, the Committee notes that the Medical Care Act, in the paragraph cited above, makes explicit reference to "reasonable compensation for insured services rendered by medical practitioners", and it is to this troublesome question that we now turn our attention.

In fact, the principles of "reasonable access" and "reasonable compensation" are connected by more than their appearance in the same paragraph of the Medical Care Act. It appears that the principal motivation behind the recent increase in opting-out is generalized dissatisfaction in the medical profession with the level of fees. It has been suggested to us that these do not now constitute "reasonable compensation", and that, as a consequence, physicians either resort to a

"revolving-door" kind of medical practice in order to maintain their incomes, or they opt-out and raise fees unilaterally. The former effect represents a dilution in the quality of care provided to patients; the latter consequence results in the "privatization" of the costs of medical care and the potential for differential access.

It is, of course, necessary to distinguish between the level of fees and the level of incomes. The evidence presented to the Committee indicates that currently the average medical practitioner in Ontario has gross annual billings of over $80,000.00 and, after practic expenses, a net annual income of over $55,000.00. This does not seem to be unreasonably low in the Committee's view. On the other hand, a fee of $7.35 for an office visit to a family physician, and a $14.00 charge for a home visit do not strike us as being adequate, or even "reasonable". These are but two examples taken from the current O.H.I.P. schedule of benefits which is based on the O.M.A. fee schedule in effect up to April 30, 1978. The dilemma confronting physicians of maintaining incomes by either diluting the level of service or by opting-out and charging higher fees threatens to generate a serious challenge to the exemplary functioning of our medical care system. It would be erroneous to portray the medical profession as interested solely, or even predominantly, in furthering its own economic self-interest. In fact, the profession has shown responsibility and self-restraint in its fee negotiations with the government since 1972. Moreover, the goodwill of the medical profession and its tradition of public service are invaluable public resources and must not be squandered in a confrontation over fees.

The Committee concludes that a policy of "cost containment" in the medical sector, which relies mainly on restricting the level of fees is unsound; it leads either to revolving-door practices with the concomitant dilution in the level of care, or to opting-out with the resulting transfer of costs (not containment) from the public to the private purse. The Committee urges the government to reconsider its policy with respect to the O.H.I.P. Schedule of Benefits. In particular, it commends to the attention of the government a system of negotiating fees and utilization rates concurrently, so as better to promote the two objectives of quality care and cost containment without economically penalizing medical practitioners. If, for example, the government were to negotiate a multi-year agreement with the profession, incorporating a substantial increase in fees in exchange for a commitment to hold constant the level of utilization (decelerate the "revolving-doors"), both these objectives could be achieved. To ensure cost containment, the fee increases for subsequent years could be made contingent on the utilization performance in the first year. Such a scheme has now been successfully (and amicably) negotiated in Quebec, and seems to be working very well on the basis of early anecdotal reports. It appears that such a scheme could address the legitimate concerns of the medical profession over the level of fees, as well as the need for responsible cost-control by the government. If so, the vexing trends in medical practice and in opting-out might be reversed, or at least mitigated.

There remains one final issue in connection with this general topic which needs to be addressed. Throughout this discussion, we have considered user charges in the form of

deterrent fees or supplementary charges by physicians only in the context of cost containment. As we noted above, however, they can alternatively be considered in the context of financing the system, that is, as a source of additional revenue. If indeed user charges are not effective deterrents overall, and utilization declines less than fees rise, then additional revenues will be generated. The Committee generally rejects this device as an appropriate way of raising revenues.

Inherent in our present medical care system is an underlying, fundamental principle that an adequate level of health-care be assured to all. Under our system, it is intended that the wealthy subsidize the poor and that the healthy subsidize the sick. User fees, by definition, shift costs to those who are sick and therefore undermine one of the basic foundations of the scheme. The Committee contends that, to further penalize those who are sick, usually a condition beyond the control of the patient, would have a very adverse compounding effect upon what are already unfortunate circumstances.

In summary, having weighed all the evidence presented to it very carefully, the Committee concludes that user charges for medical care are inappropriate at this time. Since supplementary charges by opted-out physicians are a form of user charges, the Committee is concerned about recent increases in the rate of opting-out, particularly in some communities where most physicians have exercised this option. The Committee is sensitive to the underlying causes of the disaffection of these physicians and urges the government to reconsider the mechanism for establishing the level of benefits under O.H.I.P.

HOSPITAL EFFICIENCY

The Committee learned that over 50 percent of Ontario health care costs arise out of hospital care and that it is possible, therefore, to save large sums through efficient use of these costly facilities.

Hospital representatives urged the Committee to make recommendations concerning the global budgeting system. They suggested that efficiency could be improved by providing incentives to hospitals within the budgeting process. Presently, we were told, savings arising out of efficient management are likely to be appropriated by the Ministry, and future budget levels reduced to reflect those savings. Evidence before the Committee indicated that this was seen as a serious disincentive to reduce costs.

In addition, other budgeting techniques were recommended to the Committee as a means of reducing overall hospital expenditures.

The Committee is aware that hospital budgeting procedures and the means by which those levels are established are exceedingly complex. However, it does seem sensible to the Committee that economies could be achieved if some form of incentive scheme were introduced into the budgeting procedure, whereby a legitimate cost-saving performance could be rewarded. Perhaps the "incentive reimbursement plan", in place during the early 1970's, might prove to be more effective now as a desirable incentive programme for hospitals.

The Committee agrees that some incentive should be offered to hospitals to encourage economy. We further agree that legitimate cost-savings, made through effective cost-control, should not be appropriated completely by the Ministry, but rather, at least in part, should benefit the particular hospital involved and perhaps be used to implement new programmes within the institution.

Apart from the budgeting process, we were impressed by the cost-savings potential of a number of innovative programmes presently operating in some hospitals. Increased day surgery, peer-group monitoring, like that employed at Oshawa General Hospital, and the parent care programme in British Columbia, all have potential for considerable overall cost reductions if prudently applied. These and other innovations are being developed and implemented on a local basis, but we are concerned about an apparent reluctance to accept such programmes across the whole system. This may in part be due to a lack of adequate communication, and the Ministry should ensure that new programmes which are effective are immediately and directly brought to the attention of all hospitals within the province. In addition, however, hospitals should be positively encouraged by the Ministry to adopt effective programmes, and if necessary, incentives offered through the funding mechanism. Money for new programmes should be concentrated on those hospitals which have shown a willingness to develop and employ new techniques which have resulted in cost reduction.

There was considerable discussion in the briefs and in the oral evidence received by the Committee concerning the use and abuse of emergency departments within our hospitals. The Committee simply notes that there is a difference of opinion among experts as to the relative cost of care provided at an emergency department and in the physician's office. It may well be that emergency care is no more expensive and no less effective than treatment for a similar condition in the office of the family physician. What is clear is that the role of the emergency department within our society is changing, both in the eyes of the public and the medical profession. Ministry policy should reflect that changing role, and serious consideration should be given to expanding the role of the emergency department in some of our hospitals to that of a community health clinic, offering a wider range of services. What was formerly seen as an abuse of emergency facilities may, in fact, be simply a more efficient use of existing expensive facilities at a relatively low marginal cost.

In summary, the Committee believes that the role of the hospital in today's changing circumstances must be reassessed. As the emphasis in health care shifts from institutional settings to community programmes, hospitals should be encouraged to participate in the initiation and maintenance of these programmes. The very large cost of hospital care makes it imperative that the facilities are used to maximum efficiency. New approaches involving an expansion of day surgery, home care and other related programmes should be encouraged, so as to reserve costly hospital beds for those cases in which medical judgment determines that the need justifies the high cost.

MANPOWER SUBSTITUTION

The Committee received a good deal of evidence concerning the desirability of making greater use of less costly manpower in our physician-dominated health-care delivery system. While the concept is easy to endorse, the practical problems such as legal implications, financial remuneration and acceptance by co-workers and others are more difficult. The Committee has not been able to develop specific solutions to these problems in the time available.

Particularly, the Committee has no immediate solution to the practical problem of employment for the graduates of the nurse practitioner course presently being offered at McMaster University. Nevertheless, the Committee endorses the concept of increased use of non-physician manpower in our health-care system, and feels that there is potential to reduce future costs without seriously affecting the high level of care presently enjoyed in Ontario through expansion of this type of programme.

It seems apparent, with the ever-increasing average age of Ontario residents, that the demands on the health care system and the costs of providing that service, will continue to rise in the future. We must now lay plans to meet those demands.

The Committee feels that the growing demands of older patients within the system increasingly can be met by introducing non-physician manpower, assuming an appropriate level of training. The Ministry of Health presently has targets for doctor/population ratios, and has initiated a freeze on immigration and on medical school places, to reach their general goals. This

programme could be maintained in the face of increased requirements associated with an ageing population by substituting para-medical personnel, trained in gerontology and other related disciplines. The Committee is aware that the institutions are not presently structured to provide such training. Consideration will also have to be given to defining the roles and the responsibilities of these complementary disciplines and the medical profession.

In the long term, desirable physician/population ratios could be maintained and the increased demands imposed upon the system met by less highly-trained but adequate and less costly personnel.

The short-term problem of how to employ the graduating nurse practitioners should receive more intensive consideration than was possible for this Committee to undertake this summer. In particular, it is recommended that the District Health Councils be immediately petitioned for means by which these graduates can be properly employed, so that the present programme can be maintained and hopefully extended.

PUBLIC HEALTH AND PREVENTIVE MEDICINE

The Committee was urged in a number of briefs to recommend expansion of present public health and preventive medicine programmes as a means of achieving better health and long term overall cost savings. No firm evidence was presented to the Committee as to the level of savings possible and, in fact, some suggested that there was little in the way of cost reduction which could be made which had not already been realized. Nevertheless, the

Committee believes that while the benefits cannot be measured in traditional cost/benefit terms, the people of Ontario will be better off with an increased emphasis on public health and preventive medicine.

In particular, the Committee notes that fluoridation programmes have a direct and immediate effect on dental health. The Committee recognizes that this is a matter of local autonomy, but urges the government to make known the advantages of fluoridation to the institutions responsible for its implementation and suggests that active steps be taken to encourage expansion of existing fluoridation facilities.

While the Committee learned of no new areas where preventive medicine specifically should be expanded, it was suggested that existing successful programmes had slipped, particularly in the area of immunization. Emphasis should again be placed on immunization programmes and the public awareness sharpened as to the benefits of immunization and the dangers of doing without.

Similarly, while no immediate or direct cost savings can be predicted, there should be increased emphasis on preventive health and the individual's responsibility to maintain a healthy life style. In view of the increasing public awareness of the extent of health and safety hazards in the work place the Committee recommends that occupational health and safety programmes should be expanded. School boards should encourage physical

fitness programmes within the schools with an increased emphasis on personal responsibility for overall fitness. The educational system should improve student awareness of the benefits of a healthy life style, including proper diet. The availability of so-called "junk food" or "unacceptable foods" as defined by the Ministry of Health should be restricted in the schools by those responsible. The Committee believes that a substantial improvement in the level of health within the Province can be made in the long term, if an increased awareness is implanted in our young people of the advantages of healthy personal habits.

The Committee has been made aware of an increasing problem of excessive use of alcohol and other drugs which some characterize as having reached epidemic proportions. There is no doubt that abuse of alcohol and other drugs accounts for a substantial amount of costs being imposed on the health care system. The Committee feels that substantial cost savings, quite apart from other obvious benefits, could be realized if the growing tide of alcohol abuse is brought under control. Accordingly, an aggressive programme should be instituted by the government to bring the nature of the problem and its cost consequences to the public's attention, and to encourage the reduced use of tobacco, alcohol and other harmful drugs within our society. Specifically, public advertising should be expanded in an attempt to reduce the dependence on alcohol.

CHRONIC CARE

The Committee was interested in developing means by which efficiencies within the entire system would be increased. One

problem which was brought to the Committee's attention by several groups was the anomalous situation presently existing whereby chronic care patients in hospital escape a user fee or "hotel charge" which is imposed on patients in other, lower cost institutions such as nursing homes and homes for the aged.

As was pointed out, "the sicker a person is and the more expensive the service he receives, the less he pays." Different financial consequences accrue to a resident, depending upon whether he is placed in a chronic care hospital, the extended care area of a home for the aged or nursing home, or in a residential area of a home for the aged. The charges will vary from nil in the hospital to approximately $25.00 in the home for the aged. When this is considered along with the subsidy already enjoyed by many older people for room and board through pensions, there appears to be some double subsidization for a certain segment which operates unfairly for the balance of the population.

In addition, there is the serious problem of a disincentive to placement in the proper institution based purely upon medical judgment. The present situation provides a strong financial incentive to the patient and his family to be placed in the most expensive care facility, the chronic care hospital.

The Committee agrees that the discrepancy between subsidies and charges in various institutions for long term patients constitutes a major disincentive to economic efficiency and reduced costs and, in addition, often operates unfairly.

The Committee notes that user charges with respect to this type of care are already in place in British Columbia and Manitoba. The Committee recommends that moderate per diem charges be imposed upon chronic care patients in hospitals, so as to equalize the financial burden to those in chronic care hospitals and nursing homes.

Imposition of a user charge to roughly cover costs that are no longer incurred because of institutionalization is estimated to yield approximately 25 million dollars in additional revenue per year.

A similar problem was raised by several rest home owners, who complained of the financial incentive resulting from a subsidy for "extended care patients" in nursing homes. They argue that this encourages patients to press for placement in nursing homes as "extended care patients" at higher cost to the system. They also argue that it is unfair to residents in the rest home who do not receive the subsidy and rely solely upon their own resources. While this problem is not entirely a matter of health care, the Committee believes that further consideration should be given to correcting this apparent disparity.

DATA PROCESSING AND INDIVIDUAL ENROLLMENT

Under the present O.H.I.P. system records are kept on a contract basis which includes both individuals and families. As a result, many of the data collected by O.H.I.P. on a family

basis do not allow for analysis on an individual basis. Furthermore, many of the data produced are overlapping and unreliable. The Committee repeatedly encountered difficulty in developing necessary information because of data constraints arising out of the family contract approach to record keeping.

The Committee feels that the present system of record keeping does not allow for production of reliable information in a number of important areas. It is essential that data be maintained on an individual basis so that reliable statistics can be developed on the pattern of utilization and cost incurrence. There must be more sensitivity as to why and where the costs are being incurred in order to properly control them. Accordingly, the Committee recommends that some form of individual enrollment be undertaken by O.H.I.P. which will continue to protect the confidentiality of information.

Individual enrollment will also allow flexibility in devising various tiers of premium to take into account changing circumstances, should that be deemed desirable.

The Committee therefore supports the Ministry of Health policy of developing an individual approach to enrollment in O.H.I.P. as soon as possible, making adequate provision to protect the confidentiality of the information.

As previously indicated the Committee received information concerning a number of important areas not specifically referred to in this report. The Committee also asked its staff to review and analyze reports tabled with the Standing Committee on Social Development and other related literature. That analysis was performed by Susan French under the direction of Mirv Hanna and has been summarized in a document which we believe to be of sufficient value to make part of this report as an appendix. Copies of the summary can be obtained upon request.

Copies of all briefs have been made available to the Ministry of Health for more extensive review. Some went beyond the terms of reference of the Committee and others involved issues which the Committee did not have adequate time to study in sufficient detail. However, all submissions were seriously considered and were appreciated by the Committee.

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A P P E N D I C E S

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APPENDIX A

SCHEDULE OF PUBLIC HEARINGS

Monday, July 10, 1978
Tuesday, July 11, 1978

Monday, July 17, 1978
Tuesday, July 18, 1978

Monday, July 24, 1978
Tuesday, July 25, 1978

Monday, July 31, 1978
Tuesday, August 1, 1978

Monday, August 14, 1978
Tuesday, August 15, 1978
Wednesday, August 16, 1978

Monday, August 21, 1978
Tuesday, August 22, 1978
Wednesday, August 23, 1978

Monday, August 28, 1978
Tuesday, August 29, 1978
Wednesday, August 30, 1978

Wednesday, September 6, 1978
Friday, September 8, 1978

Thursday, September 14, 1978
Friday, September 15, 1978

Appendix B

List of Submissions

Health Committee, Ontario Status of Women Council

St. Elizabeth Visiting Nurses' Association of Ontario

Canadian Federation of Independent Business - Patricia Johnston, Research Director

Edward L. Magee, M.D., 304 Belleville St., Peterborough, Ontario

Consumers' Association of Canada (Ontario)

D.H. Stephen, M.D., 2615 Danforth Avenue, Suite 18, Toronto, Ontario

Louise Marshall Hospital, 630 Dublin Street, Mount Forest, Ontario

J.A. Kiernan, M.B., Ch.B., Ph.D., Associate Professor of Anatomy, Health Sciences Centre, University of Western Ontario, London, Ontario

Francis X. Sheehan, Sheehan and Rosie Ltd. Insurance, 70 St. Paul St. West, St. Catharines, Ontario

Multiple Financial Services Ltd., W.F. Keating, Vice President, 15th Floor, 155 University Avenue, Toronto, Ontario

Edward Glazier, M.D., Glazier Medical Centre, 11 Gibb Street, Oshawa, Ontario

Ontario Dietetic Association

Ontario Provincial Conference of the International Union of Bricklayers and Allied Craftsman

The Ontario Dental Association

The Pharmaceutical Manufacturers Association of Canada

The Canadian Manufacturers' Association (Ontario Division)

Mrs. Ruth O'Donnell - Chairman, Brant District Health Council, 132 Clarence Street, Suite 202, Brantford, Ontario

John J. Mackay, Managing Director, Shouldice Hospital Limited, 7750 Bayview Avenue, Box 370, Thornhill, Ontario

C.E. Peppler, Executive Director, Ontario Association of Optometrists, Suite 212, 40 St. Clair Avenue West, Toronto, Ontario

Patients Rights Association

Ontario Pharmacists Association D.E. Pickering, President, Suite 804, 99 Avenue Road, Toronto, Ontario, M5R 2G5

Dr. G.H. Isaac, Suite 201, 2901 Lawrence Avenue East, Scarborough, Ontario, M1P 2T3

Registered Nurses' Association of Ontario, 33 Price Street, Toronto, Ontario M4W 1Z2

Ontario Nursing Home Association, 6075 Yonge Street, Willowdale, Ontario M2M 3W2

Alexandra Marine and General Hospital, 120 Napier Street, Goderich, Ontario N7A 1W5, with covering letter from J.M. Watts, M.D., F.R.C.S. (c)

Toronto Women's Health Clinic, Box 14, Station "M", Toronto, M6S 4T2

G.P. Hiebert, Vice-President, General Manager, Extendicare Ltd., One Yonge St., Toronto, M5E 1E5

Dr. Joseph F. Dietrich, Director, The Rideauwood Program, 2101 Algonquin Avenue, P.O. Box 6145, Ottawa, Ontario, K2A 1T2

Don McArthur, 65 Mary Street, Guelph, Ontario N1G 2A9

Ms. B.L. Sherman, R.R. #1, Terra Cotta, Ontario L0P 1N0

Germaine M. Urquhart, 40 Glenallan Road, Toronto M4N 1G8

Paul A. Biggin, M.A., Administrative Resident, Royal Ottawa Hospital and The School of Health Administration, 424 Queen Street, Apt. 807, Ottawa, Ontario K1R 5A8

Carol Emms, 190 Cosburn Avenue, Apt. 101, Toronto M4J 2M1

Bruce Whitestone, MacDougall, MacDougall & Mactier Ltd., P.O. Box 11, First Canadian Place, Toronto M5X 1A9

W. Ian Hay, M.B., B.S., C.C.F.P., Caroline Medical Group, 2250 Fairview Street, Burlington, Ontario L7R 4C7

Michael D. Moga, Executive Director and Secretary, Board of Governors, Peterborough Civic Hospital, Peterborough, Ontario

Ramsay W. Gunton, M.D., Department of Medicine, University Hospital, London, Ontario

C.H. Vipond, M.D., Medical Director, Rehabilitation Programmes, Oshawa General Hospital, Oshawa, Ontario

Ruth Mellor, Regional Director, Victorian Order of Nurses (Ontario), 5145 Yonge Street, Willowdale, Ontario

Daniel L. Horigan, Director, National Affairs, Canadian Federation of Independent Business, Don Mills, Ontario

Mr. Charles E. Conlon, #312, 21 Welstond Gardens, Don Mills

E.C. O'Reilly, Executive-Secretary (Acting), Association Ontario Boards of Health, 221 Portsmouth Avenue, Kingston

A.T. Clark, M.D., Vice-President, The Canadian Red Cross Society (Ontario Division), 460 Jarvis Street, Toronto

Ernst & Ernst, Management Consultants, 2200 Commerce Court West, Toronto M5L 1C6

Ontario Medical Association, 240 St. George St., Toronto

Alliance for Life, 12 Richmond St. E., Toronto M5C 1N1

R. Alan Hay, Executive Director, Ontario Hospital Association, 150 Ferrand Drive, Don Mills, Ontario M3C 1H6

Newel Smith, M.D., M.Sc., 1120 Ouellette Avenue, Windsor

Dennis J. Colby, Trustee, Toronto Board of Education, 155 College Street, Toronto

Michael Landauer, 60 MacPherson Avenue, Toronto, M5R 1W8

Stanley Oleksiuk, M.D., F.R.C.S. (c), 700 Tecumseh Road East, Suite 305, Windsor, Ontario N8X 4T2

Richard Hardie , 309 Overlea Drive, Kitchener, Ontario N2M 1T7

James L. Stouffer, Ph.D., Faculty of Medicine, Communicative Disorders, University of Western Ontario, London, Ontario, N6A 5C2

Ottawa Carleton Regional District Health Council, Suite 312, 260 Dalhousie St., Ottawa, Ontario K1N 7E4

Mr. Ian Munro, 30 DeVere Gardens, Toronto, Ontario M7A 1A2

Council of Ontario Faculties of Medicine

The Canadian Council on Social Development

College of Family Physicians of Canada (Ontario Chapter), Gary A. Gibson, M.D., C.C.F.P., President, 4000 Leslie Street, Willowdale, Ontario

Dora Atkinson, Atkinson Memorial Homes, Duart, Ontario

Mr. and Mrs. Donald Baxter, Tara Hall Rest Home, 38 Chester St., St. Thomas, Ontario

Action for Improved Medical Service, Pembroke and District, P.O. Box 433, Pembroke, Ontario. A. von Bistram, President

Mr. and Mrs. William Lidster, Sunshine Manor Rest Home, 171 Shackleton St., Dutton, Ontario. N0L 1J0

Robert S. Peat, B.A., M.D., D.P.H., F.R.C.P. (c)

Ontario Chiropractic Association, 1900 Bayview Avenue, Toronto
Mr. Richard C. Lafferty - Secretary to the Board

Charles M. Godfrey, M.A., M.D., Suite 109, 484 Church Street, Toronto, Ontario M4Y 2C7

P. Manga and C. Kapsalis, Ottawa Economists

Mae M. Caron, Reg. Nurse

The Sault Ste. Marie and District Group Health Association, F.H. Griffith - Executive Director, 240 McNabb Street, Sault Ste. Marie, Ontario

Halton District Health Council, Council Offices, P.O. Box 1086, 2324 Trafalgar Road, Oakville, Ontario

B.A.B.E. - Birthing Alternatives for a Better Experience. Ms. Judith Connell - Secretary, 6-420 Pioneer Drive, Kitchener, Ontario

P.J. Vanderburg, 34 Leroy Street, Ottawa, Ontario

Association of Ontario Boards of Health. Linda Tu, Ph.D., President

N. Gunn, D.P.M., Chairman, The Board of Regents, Chiropody (Podiatry) Act, 1944

Mr. Daniel Garrett - Emergency Physician, R.R. #1, New Hamburg, Ontario

Ontario Public Service Employees Union

Ontario Federation of Labour, Clifford Pilkey, President

Sydney Gordon, M.D.

Lucie E. Nicholson, President, Ontario Division, Canadian Union of Public Employees, Suite 301, 2 Dunbloor Road, Islington M9A 2E4

Cochrane District Health Council

Ontario Association of Homes for the Aged. Nicholas J. Manherz, Executive Director, 250 Consumers Road, Suite 903, Willowdale, Ontario. M2J 4V6

Campaign Life, Toronto, Box 5303, Station A, Toronto

District 6 (Ontario), United Steelworkers of America. Stewart Cooke, Director

W.H. Kaufman - Chairman of Waterloo Region D.H.C. (Kitchener)

Thomas Booth, 30 Sharron Drive, Toronto M6G 2A6

J.G. Carnegie, General Manager and H.G. Wilson, President, Ontario Chamber of Commerce, 2464 Yonge Street, Toronto M4P 2H5

Fred Hood, Chairman of Board of Directors, Lawrence Heights Medical Centre, 3 Replin Road, Toronto M6A 2M8

Donald G. Workman, M.D., C.C.F.P., President-Elect, Ontario Chapter, College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ontario M2K 2R9

J.C. Gillies, B.A., C.A.E., Executive Director, Ontario Dental Association, 234 St. George Street, Toronto M5R 2P1

C. Walker, M.D., F.R.C.P. (c), Assistant Professor, Division of Emergency Room Medicine, Department of Surgery, Queen's University

Mr. J. Vanderheyden

Alderman Anne Johnston, City Hall, Toronto M5H 2N2

B. Bernholtz, Professor and Chairman, Department of Industrial Engineering, University of Toronto

Professor Carolyn Tuohy, University of Toronto

Mr. H.W. Hunter, 1 Benvenuto Place, Apt. 211, Toronto, Ontario M4V 2L1

Richard Rohmer, Q.C., Suite 2319, 44 King Street West, Toronto, Ontario M5H 1E2

Don Moffat, 21 Hunter St. East, Hamilton, Ontario L8N 1M2

Naomi Page, 18 Murellen Crescent, Toronto, Ontario M4A 2K5

Carol Clarke, Chairman, Grey-Bruce District Council, 945 Third Avenue East, Suite 24, Owen Sound, Ontario N4K 2K8

Mr. David Home, Oshawa General Hospital

G.R. Musgrove, M.D., C.C.F.P., 1400 Front Road, LaSalle, Windsor, Ontario N9J 2B3

Dr. Angus Blair, Bowmanville, Ontario

Shirley Wheatley, Communications Chairperson, The Nurse Practitioners' Association of Ontario, 68 Langley Avenue, Toronto, Ontario M4K 1B5

Mr. W.G. Fleming, 48 Jessie Street, Brampton, Ontario L6Y 1L6

Lionel W.F. Rudd, 2671 Maurice Street, Sudbury, Ontario P3E 4Z2

Anna Ponte, 513 Brunswick Avenue, Toronto, Ontario

Miss Cecilia Pope, R.N., 400A Oakwood Avenue, Toronto, Ontario M6E 2W3

Mr. S. W. Martin, Chairman, Ontario Council of Health, 700 Bay Street, 14th Floor, Toronto, Ontario M5G 1Z6

Robert E. Foster, Managing Director, Canadian Association of Accident and Sickness Insurers, 55 University Avenue, Suite 1401, Toronto, Ontario M5J 2H7

Dorothy Knight, Executive Director, Ontario Physiotherapy Association, 416 Moore Avenue, Suite 304, Toronto, Ontario M4G 1C8

J.R. Ostrander, 14 St. Joseph Street, St. Thomas, Ontario N5R 1S9

Mr. Basil King, 25 Finch Avenue West, Willowdale, Ontario M2N 2G8

R.J. O'Connell, Chairman, Management Committee, Dalhousie Community Service Centre, 43 Eccles Street, Ottawa, Ontario

Appendix C

LIST OF WITNESSES

SELECT COMMITTEE ON HEALTH-CARE FINANCING AND COSTS

July 10, 1978

Ernie Hemphill

Barry Rose - Acting Deputy Minister, Ministry of Health

July 17, 1978

TEIGA Presentation

Duncan Allan, Executive Director, Fiscal Policy Division, TEIGA

Bernard Jones, Director, Taxation and Fiscal Policy Branch, TEIGA

Tom Sweeting, Senior Budget Advisor, Individual and Wealth Taxation, TEIGA

July 18, 1978

Claude Castonguay, President, Laurentian Fund

July 24, 1978

Dr. Robert George Evans, Ph.D., Associate Professor, Department of Economics, University of British Columbia

July 25, 1978

Dr. Richard Bird, Professor of Economics, University of Toronto

Dr. Stefan Dupre, Professor of Political Economics, University of Toronto

July 31, 1978

Ontario Provincial Conference of the International Union of Bricklayers and Allied Craftsmen

Danny Demonte, President

John Zanussi, Secretary-Treasuere

Art Bill, 2nd Vice-President

LIST OF WITNESSES (cont'd).

August 1, 1978

Dr. Arthur A. Stoyshin, President, Ontario Dental Association

Dr. John C. Gillies, Executive Director, Ontario Dental Association

Ontario Public Service Employees' Union

Sean O'Flynn, President

Mr. O'Grady, Research Director

Honourable Robert Welch, Deputy Premier and Minister of Culture and Recreation

Dr. Donald Aitken, Registrar, College of Physicians and Surgeons of Ontario

August 14, 1978

Ontario Medical Association

Dr. Wm. Vail, President

Dr. Ed Moran, General Secretary

August 15, 1978

Canadian Council on Social Development

Pierre Bourdon, Executive Director

Donald M. Caskie, Economic Consultant

Pharmaceutical Manufacturers Association of Canada

Mr. G. Beauchemin, Executive Vice President

Mr. J.P. Doherty, Chairman of the Board, President, General Manager, Schering Corporation Ltd.

Mr. R.E. Everson, Director of Research

Consumer's Association of Canada (Ontario)

Mrs. L.G. Rubino, Chairperson, Health Committee

August 16, 1978

Ontario Nursing Home Association

Malcolm Walker, Executive Director

Donald J. Dal Bianco, President Deem, Management

Bruce Whitestone, Economist, MacDougall & MacDougall & Mactier Ltd.

Geoffrey H. Isaac, M.D., Family Physician

LIST OF WITNESSES (cont'd).

August 21, 1978

TEIGA Presentation

Duncan Allan, Executive Director, Fiscal Policy Division, TEIGA

Bernard Jones, Director, Taxation and Fiscal Policy Branch, TEIGA

Tom Sweeting, Senior Budget Advisor, Individual and Wealth Taxation, TEIGA

Ontario Hospital Association

Dr. J.D. Galloway, President

R. Alan Hay, Executive Director

Peter Wood, Assistant Executive Director, Communications

August 22, 1978

Prof. Pran Manga, School of Health Administration, University of Ottawa

Dr. Charles Godfrey, M.A., M.D., Wellesley Hospital

Halton District Health Council

T.F. Baines, Chairman

Dr. Vern Waldorf

Wm. Leonard, Executive Director

Ontario Chiropractic Association

Lloyd Taylor, President, D.C.

Leo Rosenberg, D.C.

Lloyd MacDougall, D.C.

August 23, 1978

Extendicare Ltd.

Donald P. Schurman, Vice President, Operations

Harold L. Livergant, Chairman of the Board

G.P. Hiebert, Vice President, General Manager

Alliance for Life

Mrs. Connie Osborn, President

John Stevens, Member at Large

LIST OF WITNESSES (cont'd).

August 23, 1978

Brant District Health Council

James F. Longley, Past Chairman

Council of Ontario Faculties of Medicine

Dr. Thomas Boag, Queen's University

Dr. Martin Hollenberg, University of Western Ontario

Dr. Brian Holmes, University of Toronto

Dr. James Boone, University of Western Ontario

Dr. Fraser Mustard, McMaster University, Chairman of COFM

August 28, 1978

Toronto Women's Health Clinic

Ms. Beth Atcheson

Ms. Beth Symes

Dr. Sheila Cohen, F.R.C.S. (c)

Association of Ontario Boards of Health

Dr. Linda Tu, President

Mrs. Jean Smith

Mr. Bruce Barrett

Mr. Ed O' Reilly

Ontario Public Service Employees Union

Sean O' Flynn, President

J. O'Grady, Research Director

Bob De Matteo, Health and Safety Officer

Patients' Rights Association

David Coburn, Chairman

Mrs. Ann Coy, Vice Chairman

Harry Beatty, Secretary

Action for Improved Medical Service Pembroke & District

Alfred von Bistram

LIST OF WITNESSES (cont'd).

August 29, 1978

Ontario Federation of Labour

Clifford Pilkey, President

Terry Meagher, Secretary Treasurer

Ernst & Ernst Management Consultants

Ted Gillespie

Harold E. Josehart

The Canadian Manufacturers Association

W.W. Towill, Director of Personnel

G.A. Peckham, Labour Relations and Hourly Personnel Manager, Ford Motor Company

V.L. Thibault, Director of Economics and Communications

August 30, 1978

Dr. Sydney Gordon, Physician, Specialist in Urology

Dr. Edward Glazier, M.D., Partner, Glazier Medical Centre

United Steelworkers of America, District 6

Ken Levack, Assistant to Director

Marc Zwelling, District Representative

David Mackenzie

Ministry of Health

Dr. Richard Earle, Strategic Planning and Research Branch

September 6, 1978

Ministry of Treasury, Economics

Duncan Allan, Executive Director, Fiscal Policy Division, TEIGA

Bernard Jones, Director, Taxation and Fiscal Policy Branch, TEIGA

Tom Sweeting, Senior Budget Advisor, Individual & Wealth Taxation, TEIGA

LIST OF WITNESSES (cont'd).

September 6, 1978

Board of Regents, The Chiropody Act, Ontario

Malcolm L. Martini, Senior Economist and Planner, Hedlin Menzies and Associates

Norman Gunn, D.P.M., Chairman, Board of Regents

Mrs. Ann Frith, Lay Member, Board of Regents

David Ongley, Solicitor, Board of Regents

September 8, 1978

Prof. Carolyn Tuohy, Department of Political Economy, University of Toronto

Ontario Association of Homes for the Aged

Mr. Walter Lyons, President, O.A.H.A.

Mr. E.E. Mitchelson, Councillor

Mr. Edwin Goldstein, President, Baycrest Centre for Geriatric Care

September 14, 1978

Hon. Frank Miller, Treasurer of Ontario, Ministry of Treasury and Economics

Allan D.M., Executive Director, Fiscal Policy Division, Ministry of Treasury and Economics

Mr. David Home, Executive Director, Oshawa General Hospital

Mr. Jack McBain, Executive Director, Ontario Chamber of Commerce

Lucie E. Nicholson, President, Ontario Division, Canadian Union of Public Employees

Randy Millage, Treasurer, Ontario Division, Canadian Union of Public Employees

September 15, 1978

Hon. Dennis Timbrell, Minister of Health